

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42929

State File No. \_\_\_\_\_

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. <b>1-2929</b>  |  |
| <b>1. PLACE OF DEATH</b><br>a. COUNTY _____   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY _____  |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>   |  | c. LENGTH OF STAY (in this place)<br>_____  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>   |  | <b>2179</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4050 Magnolia Pl.</b>   |  | d. STREET ADDRESS<br><b>4050 Magnolia Pl.</b>   |  | e. STREET ADDRESS<br><b>4050 Magnolia Pl.</b>   |  | <b>0</b>   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print)<br>a. (First) <b>Hermine</b><br>b. (Middle) _____<br>c. (Last) <b>Tiemann</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>(Month) <b>Dec.</b> (Day) <b>20</b> (Year) <b>1950</b>   |  |  |  |
| <b>5. SEX</b><br><b>Female</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b><br><b>Widowed</b>   |  | <b>8. DATE OF BIRTH</b><br><b>Aug. 4, 1888</b>                               |  |
| <b>9. AGE</b> (In years last birthday) <b>62</b>  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>St. Louis, Mo.</b>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U S A</b>                          |  |
| <b>13a. FATHER'S NAME</b><br><b>Herman J. Weindel</b>   |  |   |  | <b>13b. MOTHER'S MAIDEN NAME</b><br>_____   |  | <b>14. NAME OF HUSBAND OR WIFE</b><br><b>Otto H. Tiemann</b>                 |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>No</b>   |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b><br><b>A. G. Jehle</b>               |  |
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |  |   |  | <b>19. MEDICAL CERTIFICATION</b><br><b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b><br><b>Carcinoma of Gall Bladder</b><br><br><b>ANTECEDENT CAUSES</b><br><b>Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last.</b><br><b>DUE TO (b)</b> _____<br><b>DUE TO (c)</b> _____<br><b>II. OTHER SIGNIFICANT CONDITIONS</b><br><b>metastases to liver &amp; peritoneum</b><br><b>Conditions contributing to the death but not related to the disease or condition causing death.</b> |  |  |  |
| <b>19a. DATE OF OPERATION</b><br><b>10/24/50</b>  |  |   |  | <b>19b. MAJOR FINDINGS OF OPERATION</b><br><b>Carcinoma of Gall Bladder</b>   |  |  |  |
| <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b><br>(Specify)  |  | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)                        |  | <b>21c. (CITY, TOWN, OR TOWNSHIP)</b><br><b>St. Louis</b>   |  | <b>21d. (COUNTY)</b><br><b>St. Louis</b>                                     |  |
| <b>21e. TIME OF INJURY</b><br>(Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min.) _____  |  | <b>21f. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>      |  | <b>21g. HOW DID INJURY OCCUR?</b><br><b>153X</b>  |  |  |  |
| <b>22. I hereby certify that I attended the deceased from</b> <b>8/31</b> , <b>1950</b> , <b>to</b> <b>12/20</b> , <b>1950</b> , <b>that I last saw the deceased alive on</b> <b>12/20</b> , <b>1950</b> , <b>and that death occurred at</b> <b>11:30 A.M.</b> , <b>from the causes and on the date stated above.</b> |  |   |  |   |  |  |  |
| <b>23a. SIGNATURE</b><br><b>A. F. Bergman</b>   |  |   |  | <b>23b. ADDRESS</b><br><b>2420 Washington</b>   |  | <b>23c. DATE SIGNED</b><br><b>12/21/50</b>                                   |  |
| <b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Removal</b>  |  | <b>24b. DATE</b><br><b>Dec. 22, 1950</b>  |  | <b>24c. NAME OF CEMETERY OR CREMATORY</b><br><b>Valhalla Crematory</b>  |  | <b>24d. LOCATION (City, town, or county)</b><br><b>St. Louis County, Mo.</b> |  |
| <b>DATE REC'D BY LOCAL REG.</b><br><b>DEC 21 1950</b>   |  | <b>REGISTRAR'S SIGNATURE</b><br><b>J. B. Laster</b>   |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>C. Hofmeister</b>   |  | <b>ADDRESS</b><br><b>6464 Chippewa St.</b>                                   |  |

(Licensed Embalmer's Statement on Reverse Side)

Dr. H. F. Bergman  
Beaumont Bldg.  
JE 6204

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S Broadway*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.